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STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[redacted]

DECISION
Case #: HMO - 203642

PRELIMINARY RECITALS

Pursuant to a petition filed on November 5, 2021, under Wis. Stat. § 49.45(5)(a), and Wis. Admin. Code § HA 3.03, to review a decision by the Division of Medicaid Services regarding Medical Assistance (MA), a hearing was held on December 16, 2021, by telephone.

The issue for determination is whether the petitioner's HMO correctly denied petitioner's prior authorization (PA) request for CPT codes 63030 [LAMINOTOMY (HEMILAMINECTOMY), WITH DECOMPRESSION OF NERVE ROOT(S), INCLUDING PARTIAL FACETECTOMY, FORAMINOTOMY AND/OR EXCISION OF HERNIATED INTERVERTEBRAL DISC; 1 INTERSPACE, LUMBAR] and 63057 [LAMINECTOMY, FACETECTOMY AND FORAMINOTOMY (UNILATERAL OR BILATERAL WITH DECOMPRESSION OF SPINAL CORD, CAUDA EQUINA AND/OR NERVE ROOT[S], [EG, SPINAL OR LATERAL RECESS STENOSIS]), SINGLE VERTEBRAL SEGMENT; LUMBAR] of L5-S1.

There appeared at that time the following persons:

PARTIES IN INTEREST:

Petitioner:

[redacted]

Respondent:

Department of Health Services
1 West Wilson Street, Room 651
Madison, WI 53703
By: Sandra Szabo, Member Advocate, Network Health Plan
Division of Medicaid Services
PO Box 309
Madison, WI 53701-0309

ADMINISTRATIVE LAW JUDGE:
Kelly Cochrane
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner is a resident of Racine County.
2. On August 26, 2021 the petitioner's provider submitted a PA request for petitioner to receive CPT codes 63030 and 63057 of L5-S1 to treat member's back and leg pain secondary to a diagnosis of lumbar radiculopathy with worsening symptoms (back surgery).
3. On September 7, 2021 the petitioner's HMO issued a notice to petitioner stating that his PA request was denied because it did not meet the criteria for medical necessity.

DISCUSSION

Under the discretion allowed by Wis. Stat. §49.45(9), the Department of Health Services (DHS) now requires MA recipients to participate in HMOs. Wis. Adm. Code, §DHS 104.05(2)(a). MA recipients enrolled in HMOs must receive medical services from the HMOs' providers, except for referrals or emergencies. Wis. Adm. Code §DHS 104.05(3). The criteria for approval by a managed care program contracted with the DHS are the same as the general MA criteria. See Wis. Adm. Code, §DHS 104.05(3), which states that HMO enrollees shall obtain services "paid for by MA" from the HMO's providers. The DHS must contract with the HMO concerning the specifics of the plan and coverage. See Wis. Adm. Code, §DHS 104.05(1).

The issue in this case is whether or not the HMO was correct in denying petitioner's PA request for back surgery. As explained in the notice of denial, agency's summary letter, and at hearing, the PA was denied because the petitioner did not meet the criteria for those services. Specifically, the HMO must determine whether the PA is medically necessary. Medically necessary is a term defined at Wis. Adm. Code §101.03(96m) and provides:

> **(96m)** "Medically necessary" means a medical assistance service under ch. DHS 107 that is:
> **(a)** Required to prevent, identify or treat a recipient's illness, injury or disability; and
> **(b)** Meets the following standards:
> **1.** Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
> **2.** Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
> **3.** Is appropriate with regard to generally accepted standards of medical practice;
> **4.** Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
> **5.** Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
> **6.** Is not duplicative with respect to other services being provided to the recipient;
> **7.** Is not solely for the convenience of the recipient, the recipient's family or a provider;
> **8.** With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and

9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

For petitioner, the issue relates to #2, 3 and 9 above. The HMO and DHS reviewed the medical literature for the requested service. The petitioner's issues include not having a disk that is pressing on a nerve to begin to meet the criteria for the surgery. The agencies provided citation to InterQual 2021, July 2021 release CP: Procedures Decompression +/- Fusion, Lumbar, and an UpToDate (available at https://www.uptodate.com/contents/subacute-and-chronic-low-back-pain-surgical-treatment?search=laminectomy&source=search_result&selectedTitle=2~37&usage_type=default&display_rank=2). Using evidenced based and peer reviewed medical literature, which was reviewed by at least two neurosurgeons, the agencies agreed that the requested surgery is limited to patients with nonspecific low back pain who meet the following criteria: persistent symptoms with associated disability lasting for at least one year despite nonsurgical interventions; the patient is an appropriate surgical candidate; and intensive rehabilitation with a cognitive behavioral therapy component is either not available or has not been effective. Accordingly, they determined the requested service was not consistent with standards of acceptable quality of care applicable to the type of service for this member.

Petitioner was unable to refute the evidence to show medical necessity requirements, except to say that he continues to have pain and has done a lot of things to treat the pain already, even if those actions were not documented. Unfortunately, this is not enough to overcome the medical literature evidence that supports the HMO's decision.

Accordingly, I must uphold the denial. If petitioner develops better evidence or his condition changes, his provider can always submit a new PA request.

I add, assuming petitioner finds this decision unfair, that it is the long-standing position of the Division of Hearings & Appeals that the Division's hearing examiners lack the authority to render a decision on equitable arguments. See, Wisconsin Socialist Workers 1976 Campaign Committee v. McCann, 433 F.Supp. 540, 545 (E.D. Wis.1977). This office must limit its review to the law as set forth in statutes, federal regulations, and administrative code provisions.

CONCLUSIONS OF LAW

The petitioner's HMO correctly denied petitioner's PA request for back surgery because he did not meet the criteria for medical necessity.

THEREFORE, it is ORDERED

The petition for review herein is dismissed.

REQUEST FOR A REHEARING

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision.** Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 4822 Madison Yards Way 5th Floor, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

APPEAL TO COURT

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, **and** on those identified in this decision as "PARTIES IN INTEREST" **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Milwaukee,
Wisconsin, this 14th day of January, 2022

\s_____
Kelly Cochrane
Administrative Law Judge
Division of Hearings and Appeals

State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on January 14, 2022.

Division of Medicaid Services